7. The contracted review organization forwards written notification of denial of coverage to all of the following:

   a. The attending physician

   b. The hospital, and

   c. AHCCCS/DFSM/PA.

8. The contracted review organization:

   a. Immediately notifies the AHCCCS/DFSM/PA Unit verbally, and

   b. Sends a copy of the denial letter to AHCCCS within five business days of initiation of denial.

9. For grievance system requirements, refer to 9 A.A.C. 34.

10. The contracted review organization abstracts are forwarded to AHCCCS with monthly billing, or upon specific case request.

C. MEDICAL CLAIMS REVIEW

Description. AHCCCS/DFSM/Claims conducts medical reviews of specified claims for each AHCCCS eligibility category to verify appropriateness and effectiveness of service utilization. Criteria for these medical claim reviews focus on factors including, but not limited to: diagnosis, utilization pattern, selected types of surgery and admissions. Focused medical reviews are conducted on a pre-payment basis, and may be applied to a sample of claims or all claims, depending on the reason for conducting the review.

Procedures. AHCCCS/DFSM/Claims Medical Review staff may review claims for physician and professional services rendered, hospital admissions, the level of care provided, and the length-of-stay in conjunction with the admission criteria. All transplant services are reviewed by the AHCCCS Transplant Coordinator, Division of Health Care Management (DHCM), Medical Management Unit.